		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041590

Facility Name: International Village

Address: 4815 South Western Avenue (Number) Chicago (City) 60609 (Zip Code)

County: Cook

Telephone Number: (773) 927-4200 **Fax #** (773) 927-8742

IDPA ID Number: 36-3969828-001

Date of Initial License for Current Owners: 9/11/00

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 09/11/00 to 03/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)

(Print Name and Title) Edward Slack, C.P.A.

(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	218	Skilled (SNF)	218	44,036	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	218	TOTALS	218	44,036	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	0		397	397	8
9	SNF/PED					9
10	ICF	5,259	293	9	5,561	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,259	293	406	5,958	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 13.53%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 9/11/00

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 9/11/00 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 397

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	69,510	24,501	7,150	101,161		101,161	(32,749)	68,412			1
2	Food Purchase		33,123		33,123		33,123	(3,728)	29,395			2
3	Housekeeping	29,855	17,475	1,464	48,794		48,794	(20,534)	28,260			3
4	Laundry	5,351	13,458		18,809		18,809	(12,239)	6,570			4
5	Heat and Other Utilities			194,039	194,039		194,039	(83,147)	110,892			5
6	Maintenance	44,044		250,644	294,688		294,688	(149,323)	145,365			6
7	Other (specify):*							69	69			7
8	**TOTAL General Services**	148,760	88,557	453,297	690,614		690,614	(301,651)	388,963			8
	B. Health Care and Programs											
9	Medical Director			5,250	5,250		5,250	(250)	5,000			9
10	Nursing and Medical Records	322,258	23,667	58,269	404,194		404,194	(47,472)	356,722			10
10a	Therapy	17,547	5,383	2,335	25,265		25,265	(4,587)	20,678			10a
11	Activities	27,061	7,777	3,211	38,049		38,049	(8,246)	29,803			11
12	Social Services	22,440		5,981	28,421		28,421	(10,170)	18,251			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							6,045	6,045			15
16	**TOTAL Health Care and Programs**	389,306	36,827	75,046	501,179		501,179	(64,680)	436,499			16
	C. General Administration											
17	Administrative			51,802	51,802		51,802	(15,798)	36,004			17
18	Directors Fees											18
19	Professional Services			203,744	203,744		203,744	(168,671)	35,073			19
20	Dues, Fees, Subscriptions & Promotions			56,307	56,307		56,307	(48,711)	7,596			20
21	Clerical & General Office Expenses	75,984	37,865	56,650	170,499		170,499	(86,307)	84,192			21
22	Employee Benefits & Payroll Taxes			132,629	132,629		132,629	(36,544)	96,085			22
23	Inservice Training & Education			53	53		53		53			23
24	Travel and Seminar			999	999		999	26	1,025			24
25	Other Admin. Staff Transportation			10	10		10	8	18			25
26	Insurance-Prop.Liab.Malpractice			50,423	50,423		50,423	(4,336)	46,087			26
27	Other (specify):*							4,935	4,935			27
28	**TOTAL General Administration**	75,984	37,865	552,617	666,466		666,466	(355,398)	311,068			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	614,050	163,249	1,080,960	1,858,259		1,858,259	(721,730)	1,136,529			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

International Village
0041590
COST REPORT RECLASSIFICATIONS
09/11/00
03/31/01

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS		_____
2		FOOD	_____

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX		_____
19		PROFESSIONAL FEES	_____

To reclass cost of appealing real estate taxes

Facility Name & ID Number International Village #0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			36,848	36,848		36,848	237,000	273,848			30
31	Amortization of Pre-Op. & Org.							60,087	60,087			31
32	Interest			112,962	112,962		112,962	230,526	343,488			32
33	Real Estate Taxes			270,000	270,000		270,000	73	270,073			33
34	Rent-Facility & Grounds			463,495	463,495		463,495	(463,355)	140			34
35	Rent-Equipment & Vehicles			2,131	2,131		2,131	(733)	1,398			35
36	Other (specify):*											36
37	**TOTAL Ownership**			885,436	885,436		885,436	63,598	949,034			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		31,886	27,083	58,969		58,969	(6,651)	52,318			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,054	66,054		66,054		66,054			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		31,886	93,137	125,023		125,023	(6,651)	118,372			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	614,050	195,135	2,059,533	2,868,718		2,868,718	(664,783)	2,203,935			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(21,282)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(16)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,000)	21		24
25	Fund Raising, Advertising and Promotional	(10,892)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(484,660)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (531,850)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(132,932)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (132,932)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (664,783)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

International Village

ID# 0041590

Report Period Beginning: 09/11/00

Ending: 03/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	Theft Loss	(35)	21	2
3				3
4	Pre-Operating - Dietary	(28,883)	1	4
5	Pre-Operating - Food	(3,705)	2	5
6	Pre-Operating - Housekeeping	(20,604)	3	6
7	Pre-Operating - Laundry	(12,239)	4	7
8	Pre-Operating - Utilities	(83,201)	5	8
9	Pre-Operating - Maintenance	(147,820)	6	9
10	Pre-Operating - Medical Director	(250)	9	10
11	Pre-Operating - Nursing	(55,711)	10	11
12	Pre-Operating - Rehab	(4,429)	10A	12
13	Pre-Operating - Activities	(6,438)	11	13
14	Pre-Operating - Social Service	(9,610)	12	14
15	Pre-Operating - Administation	(12,606)	17	15
16	Pre-Operating - Professional Fees	(20,624)	19	16
17	Pre-Operating - Dues, Fees	(27,917)	20	17
18	Pre-Operating - Office	(56,042)	21	18
19	Pre-Operating - Employee Benefits	(25,345)	22	19
20	Pre-Operating - Seminars	(130)	24	20
21	Pre-Operating - Insurance	(4,372)	26	21
22	Pre-Operating - Equipment Rental	(848)	35	22
23	Pre-Operating - Ancillary	(6,652)	39	23
24	Office (PPA)	(15,441)	21	24
25				25
26	Amortization of Pre-operating Costs	60,087	31	26
27				27
28	Depreciation - Loan Fees	(1,845)	30	28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
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85				85
86				86
87				87
88				88
89				89
90	**Total**	(484,660)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(28,883)		168	(3,979)		(55)						(32,749)	1
2	Food Purchase	(3,721)		(36)			29						(3,728)	2
3	Housekeeping	(20,604)		70									(20,534)	3
4	Laundry	(12,239)											(12,239)	4
5	Heat and Other Utilities	(83,201)		54									(83,147)	5
6	Maintenance	(147,820)		441	(1,944)								(149,323)	6
7	Other (specify):*			68			1						69	7
8	**TOTAL General Services**	(296,468)		765	(5,923)		(25)						(301,651)	8
	B. Health Care and Programs													
9	Medical Director	(250)											(250)	9
10	Nursing and Medical Records	(55,711)		851	(34,978)	46,135			(3,769)				(47,472)	10
10a	Therapy	(4,429)		164	(322)								(4,587)	10a
11	Activities	(6,438)		71	(1,879)								(8,246)	11
12	Social Services	(9,610)		63	(623)								(10,170)	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*			147		5,898							6,045	15
16	**TOTAL Health Care and Programs**	(76,438)		1,296	(37,802)	52,033			(3,769)				(64,680)	16
	C. General Administration													
17	Administrative	(12,606)		1,135	(39,196)	34,868	1						(15,798)	17
18	Directors Fees													18
19	Professional Services	(20,624)		299	(148,346)								(168,671)	19
20	Fees, Subscriptions & Promotions	(38,809)		44	(9,946)								(48,711)	20
21	Clerical & General Office Expenses	(86,518)		4,041	(3,831)		1						(86,307)	21
22	Employee Benefits & Payroll Taxes	(25,345)			(11,199)								(36,544)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(130)		156									26	24
25	Other Admin. Staff Transportation			7			1						8	25
26	Insurance-Prop.Liab.Malpractice	(4,372)		36									(4,336)	26
27	Other (specify):*			597		4,338							4,935	27
28	**TOTAL General Administration**	(188,404)		6,315	(212,518)	39,206	3						(355,398)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(561,310)		8,376	(256,243)	91,239	(22)		(3,769)				(721,730)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number International Village # 0041590 **Report Period Beginning:** 09/11/00 **Ending:** 03/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(23,127)	259,750	377									237,000	30
31	Amortization of Pre-Op. & Org.	60,087											60,087	31
32	Interest		230,118	408									230,526	32
33	Real Estate Taxes			73									73	33
34	Rent-Facility & Grounds		(463,495)	140									(463,355)	34
35	Rent-Equipment & Vehicles	(848)		115									(733)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	36,112	26,373	1,113									63,598	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(6,652)					1						(6,651)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(6,652)					1						(6,651)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(531,850)	26,373	9,489	(256,243)	91,239	(21)		(3,769)				(664,783)	45

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Highlander Care Center, L.L.C.		Bldg. Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32	Interest Expense	$	Highlander Care Center, L.L.C.		$ 230,118	$ 230,118	1
2	V	30	Depreciation				259,750	259,750	2
3	V	34	Rent Expense	463,495				(463,495)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 463,495			$ 489,868	$ * 26,373	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS, INC.	100.00%	$ 168	$ 168	15
16	V	2	FOOD				(36)	(36)	16
17	V	3	HOUSEKEEPING				70	70	17
18	V	5	UTILITIES				54	54	18
19	V	6	REPAIRS AND MAINT.				441	441	19
20	V	7	EMP. BEN. - GEN. SERV.				68	68	20
21	V	10	NURSING				851	851	21
22	V	10A	THERAPY				164	164	22
23	V	11	ACTIVITIES				71	71	23
24	V	12	SOCIAL SERVICES				63	63	24
25	V	15	EMP. BEN. - HEALTHCARE				147	147	25
26	V	17	ADMINISTRATIVE				1,135	1,135	26
27	V	19	PROFESSIONAL FEES				299	299	27
28	V	20	DUES, SUBSCRIPTIONS				44	44	28
29	V	21	CLERICAL AND GENERAL				4,041	4,041	29
30	V	24	SEMINARS				156	156	30
31	V	25	AUTO EXPENSE				7	7	31
32	V	26	INSURANCE				36	36	32
33	V	27	EMP. BEN. - GEN. ADMIN.				597	597	33
34	V	30	DEPRECIATION				377	377	34
35	V	32	INTEREST	0			408	408	35
36	V	33	REAL ESTATE TAXES				73	73	36
37	V	34	BUILDING RENT - UNRELATED				140	140	37
38	V	35	EQUIPMENT RENTAL				115	115	38
39	Total			$			$ 9,489	$ * 9,489	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY CONS	$ 3,979	CARE CENTERS, INC.	100.00%	$ 0	$ (3,979)	15
16	V	19	ACCOUNTING	7,500			0	(7,500)	16
17	V	19	ANCIL ADMIN FEE	13,080			0	(13,080)	17
18	V	19	BOOKEEPING	22,236			0	(22,236)	18
19	V	19	DATA PROCESSING	4,024			0	(4,024)	19
20	V	19	LEGAL	9,946			0	(9,946)	20
21	V	19	MANAGEMENT FEE	91,560			0	(91,560)	21
22	V	19	PROFESSIONAL FEES	0			0		22
23	V	20	ADVERTISING	9,946			0	(9,946)	23
24	V	25	REBILL BUS	0			0		24
25	V	0					0		25
26	V	22	HOME OFFICE PAYROLL TAX	11,199			0	(11,199)	26
27	V	1	REBILL. PAYROLL DIETARY				0		27
28	V	3	REBILL. PAYROLL HSKPNG				0		28
29	V	6	REBILL. PAYROLL MAINT.	1,944			0	(1,944)	29
30	V	10	REBILL. PAYROLL NURSING	34,978			0	(34,978)	30
31	V	10A	REBILL. PAYROLL THPY CONS.	322			0	(322)	31
32	V	11	REBILL. PAYROLL ACTIVITIES	1,879			0	(1,879)	32
33	V	12	REBILL. PAYROLL SOC. SERV.	623			0	(623)	33
34	V	17	REBILL. PAYROLL ADMIN.	39,196			0	(39,196)	34
35	V	21	REBILL. PAYROLL CLERICAL	3,831			0	(3,831)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 256,243			$ 0	$ * (256,243)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$	CARE CENTERS, INC.	100.00%	$ 46,135	$ 46,135	15
16	V	15	EMP. BEN HEALTHCARE				5,898	5,898	16
17	V	17	ADMINISTRATIVE				34,868	34,868	17
18	V	27	EMP. BEN GEN. ADMIN.				4,338	4,338	18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 91,239	$ * 91,239	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	CARE CENTERS HEALTH SYSTEMS DIVISION	100.00%	$ 15	$ 15	15
16	V	2	FOOD				29	29	16
17	V	6	MAINTENANCE				0		17
18	V	7	EMP. BEN. - GEN. SERV.				1	1	18
19	V	10	NURSING				0		19
20	V	17	ADMINISTRATIVE				1	1	20
21	V	19	PROFESSIONAL FEES				0		21
22	V	20	DUES, FEES, SUB.				0		22
23	V	21	CLERICAL & GENERAL				1	1	23
24	V	24	SEMINARS				0		24
25	V	25	TRAVEL				1	1	25
26	V	32	INTEREST				0		26
27	V	35	RENT - EQUIPMENT & VEHICLES				0		27
28	V	39	ANCILLARY ENTERAL SUPPLIES				1	1	28
29	V	1	DIETARY SUPP	70			0	(70)	29
30	V	39	ANCILLARY SUPP				0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 70			$ 49	$ * (21)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	CLERICAL AND GENERAL	$	CARE CENTERS, INC.	100.00%	$ 0	$	15
16	V	27	EMP. BEN. - GEN. SERV. EMP. BEN.				0		16
17	V	0					0		17
18	V	0					0		18
19	V	0					0		19
20	V	0					0		20
21	V	0					0		21
22	V	0					0		22
23	V	0					0		23
24	V	0					0		24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	MEDICALSUPPLIES	$	XCEL MEDICAL SUPPLLY LLC	100.00%	$ 19,871	$ 19,871	15
16	V								16
17	V								17
18	V								18
19	V	10	MEDICALSUPPLIES	23,641				(23,641)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 23,641			$ 19,871	$ * (3,769)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INS.	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 4,059	$ 4,059	15
16	V								16
17	V	22	EMPLOYEE HEALTH INS.	4,059				(4,059)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 4,059			$ 4,059	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative	0.00	see attached	0.06	0.09		$		1
2	Mark Steinberg	Relative	Administrative	0.00	see attached	0.07	0.14	CCI alloc	58	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 58		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	PATIENT DAYS	1,512,231	32	$ 128,135	$ 128,055	1,979	$ 168	1
2	2	FOOD	PATIENT DAYS	1,512,231	32	(27,254)		1,979	(36)	2
3	3	HOUSEKEEPING	PATIENT DAYS	1,512,231	32	53,695	52,345	1,979	70	3
4	5	UTILITIES	PATIENT DAYS	1,512,231	32	41,192		1,979	54	4
5	6	REPAIRS AND MAINT.	PATIENT DAYS	1,512,231	32	337,107	220,731	1,979	441	5
6	7	EMP. BEN. - GEN. SERV.	PATIENT DAYS	1,512,231	32	51,593		1,979	68	6
7	10	NURSING	PATIENT DAYS	1,512,231	32	650,209	657,173	1,979	851	7
8	10A	THERAPY	PATIENT DAYS	1,512,231	32	125,600	125,524	1,979	164	8
9	11	ACTIVITIES	PATIENT DAYS	1,512,231	32	54,474	54,163	1,979	71	9
10	12	SOCIAL SERVICES	PATIENT DAYS	1,512,231	32	48,011	48,011	1,979	63	10
11	15	EMP. BEN. - HEALTHCARE	PATIENT DAYS	1,512,231	32	112,058		1,979	147	11
12	17	ADMINISTRATIVE	PATIENT DAYS	1,512,231	32	866,963	862,068	1,979	1,135	12
13	19	PROFESSIONAL FEES	PATIENT DAYS	1,512,231	32	228,254		1,979	299	13
14	20	DUES, SUBSCRIPTIONS	PATIENT DAYS	1,512,231	32	33,513		1,979	44	14
15	21	CLERICAL AND GENERAL	PATIENT DAYS	1,512,231	32	3,087,659	2,709,599	1,979	4,041	15
16	24	SEMINARS	PATIENT DAYS	1,512,231	32	119,372		1,979	156	16
17	25	AUTO EXPENSE	PATIENT DAYS	1,512,231	32	5,310		1,979	7	17
18	26	INSURANCE	PATIENT DAYS	1,512,231	32	27,429		1,979	36	18
19	27	EMP. BEN. - GEN. ADMIN.	PATIENT DAYS	1,512,231	32	456,163		1,979	597	19
20	30	DEPRECIATION	PATIENT DAYS	1,512,231	32	288,068		1,979	377	20
21	32	INTEREST	PATIENT DAYS	1,512,231	32	311,903		1,979	408	21
22	33	REAL ESTATE TAXES	PATIENT DAYS	1,512,231	32	55,780		1,979	73	22
23	34	BUILDING RENT - UNRELATE	PATIENT DAYS	1,512,231	32	106,673		1,979	140	23
24	35	EQUIPMENT RENTAL	PATIENT DAYS	1,512,231	32	87,772		1,979	115	24
25	TOTALS					$ 7,249,679	$ 4,857,669		$ 9,489	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	DIRECT ALLOCATION		9	307,262	298,696		46,135	1
2	15	EMP. BEN HEALTHCARE	DIRECT ALLOCATION		9	39,980			5,898	2
3	17	ADMINISTRATIVE	DIRECT ALLOCATION		24	1,436,904	1,436,850		34,868	3
4	27	EMP. BEN GEN. ADMIN.	DIRECT ALLOCATION		24	191,316			4,338	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,975,462	$ 1,735,546		$ 91,239	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	HEALTH SYSTEMS INC.	2,287,765	28	496,134	378,284	70	15	1
2	2	FOOD	HEALTH SYSTEMS INC.	2,287,765	28	960,501		70	29	2
3	6	MAINTENANCE	HEALTH SYSTEMS INC.	2,287,765	28	4,392		70		3
4	7	EMP. BEN. - GEN. SERV.	HEALTH SYSTEMS INC.	2,287,765	28	47,282		70	1	4
5	10	NURSING	HEALTH SYSTEMS INC.	2,287,765	28	700		70		5
6	17	ADMINISTRATIVE	HEALTH SYSTEMS INC.	2,287,765	28	25,000		70	1	6
7	19	PROFESSIONAL FEES	HEALTH SYSTEMS INC.	2,287,765	28	7,428		70		7
8	20	DUES, FEES, SUB.	HEALTH SYSTEMS INC.	2,287,765	28	1,836		70		8
9	21	CLERICAL & GENERAL	HEALTH SYSTEMS INC.	2,287,765	28	24,796		70	1	9
10	24	SEMINARS	HEALTH SYSTEMS INC.	2,287,765	28	1,526		70		10
11	25	TRAVEL	HEALTH SYSTEMS INC.	2,287,765	28	43,326		70	1	11
12	32	INTEREST	HEALTH SYSTEMS INC.	2,287,765	28	1,489		70		12
13	35	RENT - EQUIPMENT & VEHIC	HEALTH SYSTEMS INC.	2,287,765	28	2,182		70		13
14	39	ANCILLARY ENTERAL SUPPL	HEALTH SYSTEMS INC.	2,287,765	28	32,397		70	1	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,648,989	$ 378,284		$ 49	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARE CENTERS, INC.
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-9090
Fax Number: (708)449-7070

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	CLERICAL AND GENERAL	DIRECT ALLOCATION	100	1	31,075	31,075			1
2	27	EMP. BEN. - GEN. SERV. EMP.	DIRECT ALLOCATION	100	1	4,401				2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 35,476	$ 31,075		$	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY LLC
Street Address: 150 FENCL LANE
City / State / Zip Code: HILLSIDE, IL. 60162
Phone Number: (708)449-2330
Fax Number: (708)449-3236

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	MEDICALSUPPLIES	DIRECT ALLOCATION			$	$		$ 19,871	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 19,871	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP
Street Address: 4101 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INS.	DIRECT ALLOCATION			$	$		$ 4,059	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 4,059	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Corus Bank		X	Constuction Loan			$	$ 9,500,000			$ 230,118	1
2												2
3												3
4												4
5												5
	Working Capital											
6	A1 Corp		X	Insurance Financing							707	6
7	Care Centers, Inc.	X		Working Capital							39,553	7
8	Shareholders	X		Working Capital				950,000			72,702	8
9	TOTAL Facility Related						$	$ 10,450,000			$ 343,080	9
	B. Non-Facility Related*											
10	Supplemental Schedule											10
11	Allocation from Care Center										408	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 408	14
15	TOTALS (line 9+line14)						$	$ 10,450,000			$ 343,488	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$	21

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	73	2
3. Under or (over) accrual (line 2 minus line 1).	$	73	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	270,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	270,073	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995		8
1996		9
1997		10
1998		11
1999		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Real Estate Tax allocated from Care Centers $73 (included on line 2)

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 89,132 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 542,867
2. Number of Years Over Which it is Being Amortized: 5
3. Current Period Amortization: 60,087
4. Dates Incurred: Prior to 9/11/00

Nature of Costs: various pre-operating expenses
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	115,710	1995	$ 901,533	1
2					2
3	TOTALS	115,710		$ 901,533	3

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	218		2000	2000	$ 12,627,413	$ 165,263	35	$ 210,457	$ 45,194	$ 210,457	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	OUTSIDE SIGNS			2000	1,445	19	20	42	23	42	9
10	SIGNS			2000	5,260	68	20	154	86	154	10
11	TELEPHONE WIRING			2000	1,884	18	20	42	24	42	11
12	LANDSCAPING			2000	3,861	51	20	112	61	112	12
13	DECORATING			2000	1,871	25	20	54	29	54	13
14	LIGHTING SUPPLIES			2000	127	2	20	4	2	4	14
15	LIGHTING SUPPLIES			2000	144	2	20	4	2	4	15
16	REMOVING DEBRIS			2000	7,000	91	20	205	114	205	16
17	SHOWER CURTAINS			2000	1,065	14	20	32	18	32	17
18	ALARM SEC SERVICES			2000	16,517	217	20	481	264	481	18
19	SIGNS			2000	2,439	32	20	72	40	72	19
20	LAWN SPRINKLER SYSTM			2000	17,000	222	20	495	273	495	20
21	ALARM SYSTEM INSTALL			2000	17,000	222	20	495	273	495	21
22	ELECTRICAL WIRING			2000	656	2	20	5	3	5	22
23	SIGNS			2000	360	5	20	11	6	11	23
24											24
25	PAGE 12-1 REP TOTALS				1,866	50		62	12	249	25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34	PAGE 12B TOTALS				8,046						34
35	PAGE 12A TOTALS				100,928	991		2,263	1,272	2,263	35
36	TOTAL (lines 4 thru 35)				$ 12,814,882	$ 167,294		$ 214,990	$ 47,696	$ 215,177	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHTING SUPPLIES			2000	178	2	20	5	3	5	9
10	SPRINKLER			2000	3,000	39	20	88	49	88	10
11	HAGEMASTER DEBRIS			2000	4,880	63	20	142	79	142	11
12	TELEPHONE WIRING			2000	642	9	20	19	10	19	12
13	AVIARY			2000	14,628	191	20	427	236	427	13
14	ELECTRICAL WIRING			2000	327	2	20	5	3	5	14
15	ELECTRICAL WIRING			2000	375		20	4	4	4	15
16	ELECTRICAL WIRING			2000	421		20	4	4	4	16
17	SIGNS			2000	4,000	53	20	117	64	117	17
18	VOICE ALARM			2000	337	5	20	11	6	11	18
19	INSTALL OF SATELLITE			2000	2,920	28	20	65	37	65	19
20	218 OUTLETS			2000	18,495	103	20	270	167	270	20
21	ELECTRICAL WIRING			2000	6,161	35	20	89	54	89	21
22	LIGHTING SUPPLIES			2000	923	12	20	26	14	26	22
23	ELECTRICAL WIRING			2000	468	4	20	7	3	7	23
24	TELEPHONE WIRING			2000	4,542	60	20	133	73	133	24
25	ELECTRICAL WIRING			2000	197	2	20	4	2	4	25
26	OUTLETS FOR TV UNITS			2000	1,508	9	20	23	14	23	26
27	LIGHTING SUPPLIES			2000	258	4	20	7	3	7	27
28	LANDSCAPING			2000	1,155	16	20	33	17	33	28
29	LIGHTING SUPPLIES			2000	879	12	20	26	14	26	29
30	VOICE ALARM			2000	903	12	20	26	14	26	30
31	VOICE ALARM			2000	24,785	326	20	723	397	723	31
32	SIGNS			2000	127	2	20	4	2	4	32
33	ELECTRICAL WIRING			2000	296	2	20	5	3	5	33
34	STORAGE SYSTEM			2001	7,961		20				34
35	TELEPHONE WIRING			2001	562		20				35
36	TOTAL (lines 4 thru 35)				$ 100,928	$ 991		$ 2,263	$ 1,272	$ 2,263	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CCTV			2001	1,196		20				9
10	CCTV			2001	641		20				10
11	DRAPERY			2001	2,324		20				11
12	CUBICLE CURTAINS			2001	1,632		20				12
13	TELEPHONE WIRING			2001	419		20				13
14	TELEPHONE WIRING			2001	555		20				14
15	TELEPHONE WIRING			2001	419		20				15
16	SURGE SUPPRESSOR			2001	860		20				16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 8,046	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			CCI alloc.	1996	$ 1,482	$ 38	35	$ 42	$ 4	$ 173	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation from Care Centers, Inc.			2000	2		20				9
10	Allocation from Care Centers, Inc.			1999	27	1	20	1		3	10
11	Allocation from Care Centers, Inc.			1998	11		20	1	1	1	11
12	Allocation from Care Centers, Inc.			1997	155	4	20	9	5	42	12
13	Allocation from Care Centers, Inc.			1996	171	2	20	8	6	28	13
14	Allocation from Care Centers, Inc.			1997	18	4	20	1	(3)	2	14
15	Allocation from Care Centers, Inc.			1994		1	20		(1)		15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,866	$ 50		$ 62	$ 12	$ 249	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,257	$ 163	$ 136	$ (27)		$ 583	37
38	Current Year Purchases	1,019,946	127,520	58,613	(68,907)		58,613	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,021,203	$ 127,683	$ 58,749	$ (68,934)		$ 59,196	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Allocation from Care Centers			$ 704	$ 153	$ 109	$ (44)	10	$ 244	42
43										43
44										44
45										45
46	TOTALS			$ 704	$ 153	$ 109	$ (44)		$ 244	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 14,738,322	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 295,130	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 273,848	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (21,282)	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 274,617	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Loan Fees	$ 110,665	$ 3,227	$ 3,227	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 110,665	$ 3,227	$ 3,227	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

International Village
0041590
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
03/31/01

LINE 28: PRIOR YEARS

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
International Village					
Care Centers, Inc.	1,257	163	136	(27)	583
Highlander Care Center, L.L.C.					
TOTALS	1,257	163	136	(27)	583

LINE 29: CURRENT YEAR

International Village	225,812	34,866	12,290	(22,576)	12,290
Care Centers, Inc.	71	12	2	(10)	2
Highlander Care Center, L.L.C.	794,063	92,642	46,321	(46,321)	46,321
TOTALS	1,019,946	127,520	58,613	(68,907)	58,613

LINE 30: FULLY DEPRECIATED

International Village					
Care Centers, Inc.					
Highlander Care Center, L.L.C.					
TOTALS					

TOTALS (Should Tie to Totals on Page 13)

International Village	225,812	34,866	12,290	(22,576)	12,290
Care Centers, Inc.	1,328	175	138	(37)	585
Highlander Care Center, L.L.C.	794,063	92,642	46,321	(46,321)	46,321
TOTALS	1,021,203	127,683	58,749	(68,934)	59,196

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - Related Party

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Allocation from Care Center				140			5
6								6
7	TOTAL				$ 140 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,398 Description: Copier $1093, Time Clock $190, Alloc from CCI $115
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number International Village

STATE OF ILLINOIS
0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 7,764	$		$ 7,764	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			1,041			1,041	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			18,277			18,277	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				9,616		9,616	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**	39-2					22,270		22,270	13
14	TOTAL			$ 0		$ 27,082	$ 31,886		$ 58,968	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	17,291
2	Air Fluidized Beds	2,800
3	Radiology	745
4	Enteral	168
5	Lab	238
6	Respiratory Supplies	1,028
7		
8		
9		
10		
		22,270

	Outside Therapies (Column 5 - Other)	Amount
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

STATE OF ILLINOIS

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 03/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,634	$ 1,634	1
2	Cash-Patient Deposits	4,985	4,985	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	572,312	572,312	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	36,184	36,184	6
7	Other Prepaid Expenses	2,638	2,638	7
8	Accounts Receivable (owners or related parties)	551,224	551,224	8
9	Other(specify): See supplemental schedule	3,839	1,311,839	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,172,816	$ 2,480,816	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		901,533	13
14	Buildings, at Historical Cost		12,627,413	14
15	Leasehold Improvements, at Historical Cost	185,606	185,606	15
16	Equipment, at Historical Cost	225,814	1,019,877	16
17	Accumulated Depreciation (book methods)	(36,848)	(296,598)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		110,665	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 374,572	$ 14,548,496	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,547,388	$ 17,029,312	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 163,159	$ 818,278	26
27	Officer's Accounts Payable		3,942,985	27
28	Accounts Payable-Patient Deposits	2,783	2,783	28
29	Short-Term Notes Payable	950,000	950,000	29
30	Accrued Salaries Payable	1,568,053	1,568,053	30
31	Accrued Taxes Payable (excluding real estate taxes)	14,239	14,239	31
32	Accrued Real Estate Taxes(Sch.IX-B)	270,000	270,000	32
33	Accrued Interest Payable	72,702	72,702	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	463,623	1,249,226	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,504,559	$ 8,888,266	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		9,500,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 9,500,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,504,559	$ 18,388,266	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,957,171)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,547,388	$ #REF!	48

*(See instructions.)

Facility Name & ID Number International Village # 0041590 **Report Period Beginning:** 09/11/00 **Ending:** 03/31/01

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 03/31/01

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	2,180	2,180
A/R Employees	1,659	1,659
Subscription Receivable		1,308,000
	3,839	1,311,839

OTHER CURRENT LIABILITIES:	Amount	Amount
Deferred Rent	463,495	463,495
Wage Assignments	128	128
Inbilled Construction		785,603
	463,623	1,249,226

OTHER NON CURRENT ASSETS:		
Loan Fees		110,665
		110,665

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3	CAPITAL CONTRIBUTIONS	228,000	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 228,000	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,185,171)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,185,171)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,957,171)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	International Village	#	0041590	Report Period Beginning:	09/11/00	Ending:	03/31/01

Balance per General Ledger		(1,344,247)
Adjustments:		
		-
		-
		-
CAPITAL CONTRIBUTIONS		228,000
Total adjustments		228,000
Balance - Beginning of Year		(1,116,247)
Equity(Deficit) from Page 17 Col 1		(1,957,171)
Related Party		
Equity(Deficit)	1088085	
Income	-489868	
		598,217
Combined Equity - End of Year		(1,358,954)

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 665,699	1
2	Discounts and Allowances for all Levels	(121,084)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 544,615	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,140	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 114,140	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(215)	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	9,561	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,407	19
20	Radiology and X-Ray	1,490	20
21	Other Medical Services	10,549	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 24,792	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See supplemental schedule		28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 683,547	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	690,614	31
32	Health Care	501,179	32
33	General Administration	666,466	33
	B. Capital Expense		
34	Ownership	885,436	34
	C. Ancillary Expense		
35	Special Cost Centers	58,969	35
36	Provider Participation Fee	66,054	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,868,718	40
41	**Income before Income Taxes (line 30 minus line 40)****	(2,185,171)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (2,185,171)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? no-cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number **International Village** **# 0041590** **Report Period Beginning:** **09/11/00** **Ending:** **03/31/01**

SUPPLEMENTAL SCHEDULE OF REVENUES
03/31/01

	DESCRIPTION	AMOUNT
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,221	1,370	32,495	23.72	2
3	Registered Nurses	2,512	2,754	52,103	18.92	3
4	Licensed Practical Nurses	7,023	7,435	125,772	16.92	4
5	Nurse Aides & Orderlies	12,878	14,164	106,365	7.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,098	1,157	17,546	15.17	8
9	Activity Director	1,147	1,202	14,739	12.26	9
10	Activity Assistants	1,620	1,656	12,322	7.44	10
11	Social Service Workers	1,415	1,459	22,440	15.38	11
12	Dietician					12
13	Food Service Supervisor	1,375	1,468	20,183	13.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	6,131	6,501	49,327	7.59	15
16	Dishwashers					16
17	Maintenance Workers	2,988	3,333	44,043	13.21	17
18	Housekeepers	4,470	4,574	29,855	6.53	18
19	Laundry	807	819	5,351	6.53	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,008	6,343	75,984	11.98	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	722	735	5,523	7.51	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	51,415	54,970	$ 614,048 *	$ 11.17	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	81/monthly	$ 7,150	1-3	35
36	Medical Director	monthly	5,250	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	29	1,283	10-3	38
39	Pharmacist Consultant	monthly	2,762	10-3	39
40	Physical Therapy Consultant	27	1,338	10A-3	40
41	Occupational Therapy Consultant	14	675	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	28	1,332	11-3	44
45	Social Service Consultant				45
46	Other(specify)				46
47	CCI payroll (see attached)		62,407		47
48					48
49	TOTAL (lines 35 - 48)	98	$ 82,197		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$ 0		53

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 0

B. Administrative - Other

Description	Amount
Administrator salary paid by CCI (adjusted out on 6B)	$ 51,802
TOTAL (agree to Schedule V, line 17, col. 3)	$ 51,802
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 18,046
Winston & Strawn	Legal	31,805
IIT / Sourcetech	Data Processing	1,035
Alpha Data Services	Data Processing	1,228
Maxxsource	Data Processing	600
Personnel Planners	Unemployment Consultant	844
Academy	Translation	1,840
Care Centers, Inc.	various - see attached	148,346
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 203,744

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 16,696
Unemployment Compensation Insurance	22,044
FICA Taxes	40,544
Employee Health Insurance	8,697
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expense	1,118
Employee Physical	1,545
Misc. Employee Welfare	1,031
Christmas Expense	4,410
TOTAL (agree to Schedule V, line 22, col.8)	$ 96,085

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,980
Health Care Worker Background Check	63
(Indicate # of checks performed 9)	
Advertising & Promotion	10,892
Dues & Subscriptions	112
Licenses & Fees	5,398
Allocation from Care Centers	44
Less: Public Relations Expense	( )
Non-allowable advertising	(10,892)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,597

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	869
Allocation from Care Centers	156
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,025

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number International Village # 0041590 Report Period Beginning: 09/11/00 Ending: 03/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
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12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **301** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,054**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **NONE**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees